forcement action with respect to the plan's or issuer's crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section [enacting this section and sections 300gg–1, 300gg–11 to 300gg–13, 300gg–21 to 300gg–23, 300gg–91, and 300gg–92 of this title and amending sections 300e and 300bb–8 of this title].

''(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2)(B), in the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act [Aug. 21, 1996], part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (other than section 2701(e) [now 2704(e)] thereof [42 U.S.C. 300gg–3(e)]) shall not apply to plan years beginning before the later of—

''(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

''(B) July 1, 1997.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement of such part shall not be treated as a termination of such collective bargaining agreement.

''(4) TIMELY REGULATIONS.—The Secretary of Health and Human Services, consistent with section 104 [42 U.S.C. 300gg–92 note], shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section [enacting this section and sections 300gg–1, 300gg–11 to 300gg–13, 300gg–21 to 300gg–23, 300gg–91, and 300gg–92 of this title and amending sections 300e and 300bb–8 of this title] and section 111 [enacting sections 300gg–41 to 300gg–44 and 300gg–61 to 300gg–63 of this title].

''(5) LIMITATION ON ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before January 1, 1998, or, if later, the date of issuance of regulations referred to in paragraph (4), if the plan or issuer has sought to comply in good faith with such requirements.''

CONGRESSIONAL FINDINGS RELATING TO EXERCISE OF COMMERCE CLAUSE AUTHORITY; SEVERABILITY

Pub. L. 104–191, title I, §195, Aug. 21, 1996, 110 Stat. 1991, provided that:

''(a) FINDINGS RELATING TO EXERCISE OF COMMERCE CLAUSE AUTHORITY.—Congress finds the following in relation to the provisions of this title [enacting this subchapter and sections 1181 to 1183 and 1191 to 1191c of Title 29, Labor, amending sections 233, 300e, and 300bb–8 of this title and sections 1003, 1021, 1022, 1024, 1132, 1136, and 1144 of Title 29, and enacting provisions set out as notes under this section, section 300gg–92 of this title, and section 1181 of Title 29]:

''(1) Provisions in group health plans and health insurance coverage that impose certain preexisting condition exclusions impact the ability of employees to seek employment in interstate commerce, thereby impeding such commerce.

''(2) Health insurance coverage is commercial in nature and is in and affects interstate commerce.

''(3) It is a necessary and proper exercise of Congressional authority to impose requirements under this title on group health plans and health insurance coverage (including coverage offered to individuals previously covered under group health plans) in order to promote commerce among the States.

''(4) Congress, however, intends to defer to States, to the maximum extent practicable, in carrying out such requirements with respect to insurers and health maintenance organizations that are subject to State regulation, consistent with the provisions of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.].

''(b) SEVERABILITY.—If any provision of this title or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this title and the application of the provisions of such to any person or circumstance shall not be affected thereby.''

HEALTH COVERAGE AVAILABILITY STUDIES

Pub. L. 104–191, title I, §191, Aug. 21, 1996, 110 Stat. 1987, directed the Secretary of Health and Human Services to provide for a study on the effectiveness of the provisions of title I of Pub. L. 104–191 and the various State laws, in ensuring the availability of reasonably priced health coverage to employers and individuals and a study on access to, and choice of, health care providers and the cost and cost-effectiveness to health insurance issuers of providing access to out-of-network providers, and the potential impact of providing such access on the cost and quality of health insurance coverage, and to report to the appropriate committees of Congress on each of such studies not later than Jan. 1, 2000.

§ 300gg–1. Guaranteed availability of coverage

(a) Guaranteed issuance of coverage in the individual and group market

Subject to subsections (b) through (e),[1] each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

(b) Enrollment

(1) Restriction

A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

(2) Establishment

A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 1163 of title 29).

(3) Regulations

The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

(c) Special rules for network plans

(1) In general

In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may—

(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that—

(i) it will not have the capacity to deliver services adequately to enrollees of

[1] So in original.

any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals[1] employees and dependents.

(2) 180-day suspension upon denial of coverage

An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the group or individual market within such service area for a period of 180 days after the date such coverage is denied.

(d) Application of financial capacity limits

(1) In general

A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees and dependents.

(2) 180-day suspension upon denial of coverage

A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group or individual market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

(July 1, 1944, ch. 373, title XXVII, §2702, as added and amended Pub. L. 111–148, title I, §§1201(4), 1563(c)(8), formerly §1562(c)(8), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 156, 266, 911.)

CODIFICATION

The text of section 300gg–11 of this title, which was amended and transferred to subsecs. (c) and (d) of this section by Pub. L. 111–148, §1563(c)(8), formerly §1562(c)(8), as renumbered by Pub. L. 111–148, §10107(b)(1), was based on act July 1, 1944, ch. 373, title XXVII, §2731, formerly §2711, as added Pub. L. 104–191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1962; renumbered §2731, Pub. L. 111–148, title I, §1001(3), Mar. 23, 2010, 124 Stat. 130.

PRIOR PROVISIONS

A prior section 300gg–1, act July 1, 1944, ch. 373, title XXVII, §2702, as added Pub. L. 104–191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1961; Pub. L. 110–233, title I, §102(a)(1)–(3), May 21, 2008, 122 Stat. 888, 890, which related to prohibition on discrimination against individual participants and beneficiaries based on health status, was amended by Pub. L. 111–148, title I, §1201(3), Mar. 23, 2010, 124 Stat. 154, effective for plan years beginning on or after Jan. 1, 2014, and was transferred to subsecs. (b) to (f) of section 300gg–4 of this title.

Another prior section 2702 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238a of this title.

AMENDMENTS

2010—Pub. L. 111–148, §1563(c)(8), formerly §1562(c)(8), as renumbered by Pub. L. 111–148, §10107(b)(1), transferred section 300gg–11 of this title to the end of this section after amending it by striking out the section catchline ''Guaranteed availability of coverage for employers in group market'', by striking out subsec. (a) which related to issuance of coverage in small group market, subsec. (b) which related to assurance of access in large group market, subsec. (e) which related to exception to requirement for failure to meet certain minimum participation or contribution rules, and subsec. (f) which related to exception for coverage offered only to bona fide association members, by amending subsec. (c) by substituting ''group and individual'' for ''small group'' in introductory provisions of par. (1), inserting ''and individuals'' after ''employers'' in introductory provisions of par. (1)(B), inserting ''or any additional individuals'' after ''additional groups'' in par. (1)(B)(i), substituting ''and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals'' for ''without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such'' in par. (1)(B)(ii), and substituting ''group or individual'' for ''small group'' in par. (2), and by amending subsec. (d) by substituting ''group or individual'' for ''small group'' wherever appearing and substituting ''all employers and individuals'' for ''all employers'', ''those individuals, employers'' for ''those employers'', and ''such individuals, employees'' for ''such employees'' in par. (1)(B).

EFFECTIVE DATE

Section effective for plan years beginning on or after Jan. 1, 2014, see section 1255 of Pub. L. 111–148, set out as a note under section 300gg of this title.

§ 300gg–2. Guaranteed renewability of coverage

(a) In general

Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

(b) General exceptions

A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a health insurance coverage offered in the group or individual market based only on one or more of the following:

(1) Nonpayment of premiums

The plan sponsor, or individual, as applicable, has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.